COUNCIL FOR MEDICAL SCHEMES APPEALS COMMITTEE

(CENTURION)

In the matter between

OTTO, H Appellant

and

DISCOVERY HEALTH MEDICAL SCHEME Respondent

RULING

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1. This is an appeal in terms of the Medical Schemes Act, 131 of 1998 (**"the MSA"**) against the ruling of the Registrar of Medical Schemes (**"the Registrar"**) dated 10 November 2015. The appeal is dated 13 January 2016 and is lodged purportedly in terms of section 48 of the MSA – **"purportedly"** because the document articulating the appeal hardly meets the requirements for an

affidavit. Section 48 requires that an appeal be lodged **"in the form of an affidavit"**. Nevertheless, the scheme has not made an issue of this non-compliance.

2. In its ruling the registrar's office held that the scheme was not liable to fund the procedure in question in full (even though breast cancer is a PMB condition) because the appellant voluntarily used the services of a non-DSP (designated service provider) when there were DSPs available within reasonable distance of the appellant's residence, and the procedure was not performed in emergency circumstances.

3. In her appeal, the appellant says the scheme's decision to fund the first round of treatment but decline to fund subsequent treatment is **"onaanvaarbaar en onmenslik"** (unacceptable and inhuman). But the scheme has explained that funding the first stage was an error and so it did not reclaim it. That can hardly be characterised as **"unacceptable and inhuman"**. She does not deny that there were DSPs available within reasonable distance of her residence.

4. Medial schemes are bound by the provisions of their registered rules and the provisions of the MSA and other applicable legislation. The

rules are binding on members and everyone who claims in terms of those rules (see section 32 of the MSA). Even in the treatment of a PMB condition, the scheme must apply managed health care principles in order to ensure efficiency, cost-effectiveness and affordability as regulation 8(4) to the MSA permits it to do. These include treatment protocols, pre-authorisation, use of formularies and use DSPs.

5. There are 3 exceptions, listed in regulation 8(3), to the prohibition of voluntary use of non-DSPs. It is not necessary to determine whether or not these constitute a closed list. There is no clinical evidence justifying deviation from them. These exceptions are:

5.1 where service from a DSP was either not available or would not be obtained without unreasonable delay; or

5.2 where immediate medical or surgical treatment for a PMB condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining treatment from a DSP; or

5.3 where there is no DSP within reasonable proximity.

6. The facts in this case fit none of these scenarios.

7. The scheme also contends that fat graft is funded only if it meets its protocol. It says its protocol does not permit for fat graft as a stand-alone method of breast reconstruction. The appellant does not dispute this.

8. In any event, while breast cancer is a PMB condition, the treatment to be funded in full must still be PMB level of care. The DTPs (Diagnosis and Treatment Pairs) recommends **"medical and surgical management"** as treatment for breast cancer. That triggers paragraph (2) of the explanatory notes to the DTPs. In this regard, the position as we understand it is as follows:

   8.1 Paragraph (2), which takes its cue from the description of the recommended treatment for PMB Code 950J as **"medical and surgical management"**, says where the treatment component of a prescribed minimum benefit condition is described in general terms (for example **"surgical management"**), then the treatment should be taken as

referring to **"prevailing hospital-based"** treatment regime for the condition in question.

8.2 Where there are **"significant differences"** between the treatment practices in private hospitals, on the one hand, and public hospitals, on the other, then the **"predominant public hospital"** treatment regime must be followed as outlined in their clinical treatment protocols.

8.3 Where no such clinical protocols exist, then disputes about the prevailing public hospital treatment regime must be settled by consultation with provincial health authorities.

9. A number of considerations emerge from paragraph (2) of the explanatory note which tend to be glossed over in arguments that are based on it.

9.1 First, the treatment component of the condition must be couched in general terms (stage 1).

9.2 Second, the condition in question must be a prescribed minimum benefit condition (stage 2).

9.3 Third, the treatment expressed in general terms must be interpreted as referring to prevailing (not predominant) hospital-based treatment regime for that condition, whether in private hospitals or in public hospitals (stage 3).

9.4 Fourth, only where there are significant differences in the prevailing treatment for that condition between treatment provided in private hospitals on the one hand, and that which is provided in public hospitals, on the other, can predominant public hospital treatment regime for that condition be followed (stage 4).

9.5 Fifth, the predominant public hospital treatment regime is that which is outlined in the public hospitals' clinical protocols. Absent such a clinical protocol, then there is no predominant public hospital treatment regime for the condition in question (stage 5).

9.6 Sixth, in the absence of such a public hospital clinical protocol, then disputes as regards the predominant public hospital treatment regime for a prescribed minimum benefit

condition must be resolved by consultation with provincial health authorities. In other words, whatever the provincial health authorities say is the predominant public hospital treatment regime for a specific prescribed minimum benefit condition for the treatment of which there is no existing clinical protocol, is binding (stage 6).

10. In this case, there is no suggestion that fat graft as a stand-alone intervention is prevailing hospital-based treatment for breast cancer. So the other considerations from stage 4 to stage 6 are not triggered.

11. In the circumstances, the appeal cannot succeed for <u>any one</u> of three reasons:

11.1 voluntary use of a non-DSP in circumstances where there were DSP within reasonable proximity of the appellant's residence and the intervention was not an emergency; or

11.2 fat grafting as a stand-alone intervention is not PMB level of care for breast cancer; or

11.3 Payment by the scheme for a procedure in error does not give rise to a legitimate expectation in the circumstances of this case.

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VUYANI NGALWANA SC for Appeals Committee

For the appellant: H Otto

For the scheme: N Taitz; S Singh; Dr N Madhlopha

For the registrar: M Winkler

Date of hearing: 16 September 2016
Date of Ruling: 15 October 2016